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ABSTRACT

Hudson Valley Migrant Health (HVMH) (a Public Health Service program) collaborated with the Center for Disease Control (CDC) and the New York State Department of Health (NYSDOH) on a study of the incidence of sexually transmitted diseases and tuberculosis among migrant farmworkers in the mid-Hudson region of New York. CDC research personnel screened 115 migrant workers from August 31 to September 12, 1992, distributed results, and initiated treatment. HVMH assumed primary responsibility for follow-up. Other agencies offered support during both phases of the study. Screening results indicated a 36 percent tuberculosis positivity, 6 percent HIV positivity, and 32 percent syphilis positivity. In addition, 32 percent lacked immunity to the Hepatitis B virus. Barriers to providing screening and health care include: (1) limited hours of access both by farmworkers to health care, and by providers to farmworkers because of work schedules; (2) underdeveloped linkages with county departments of health; (3) travel distances and lack of transportation for follow-up; (4) inefficient transfer of medical information upstream and downstream; and (5) limited staff and financial resources of HVMH for the extensive follow-up required. Nine recommendations are offered; they include adopting more positive attitudes toward farmworkers; improving collaboration and coordination among agencies; coordinating interstate Medicaid coverage; establishing outreach, health education, translation, and transportation services; and increasing the role of the Public Health Service. (KS)

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REFLECTIONS AND RECOMMENDATIONS BASED ON A MIGRANT HEALTH CENTER'S PARTICIPATION IN A CDC STUDY

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HUDSON VALLEY MIGRANT HEALTH
of the
PEEKSKILL AREA HEALTH CENTER, INC.

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OVERVIEW

Hudson Valley Migrant Health (HVMH), a Public Health Service funded program of the Peekskill Area Health Center, collaborated with the Center for Disease Control (CDC) and the New York State Department of Health (NYSDOH) on a study of the incidence of sexually-transmitted diseases and tuberculosis among migrant farmworkers in the mid-Hudson region of New York, an area 50 miles north of New York City along the Hudson River.

One hundred fifteen (115) migrant workers from seven farms in three counties were screened by CDC research personnel during the two-week period of August 31 to September 12, 1992. The observations in this report are drawn from this experience by Migrant Health staff, and the recommendations are applicable to promoting collaboration among state departments of health, migrant/community health centers, and the CDC.

In early August, initial contact was made between the NYSDOH and Hudson Valley Migrant Health to discuss the possibility of extending an East Coast study by the CDC to New York State. A meeting of all the principals was held in Albany, the State Capitol, with follow-up conference calls a week later. The screening was set to begin less than a month after the initial contact. This first phase consisted of a week of screening and testing, followed by another week for distributing results and initiating treatment. This phase was conducted by the CDC study team, with the support of the NYSDOH STD Program and Migrant Health staff. A second phase of the follow-up became primarily the responsibility of the PHS grantee, Hudson Valley Migrant Health, supported by the NYSDOH STD and TB Programs, and the local county departments of health.

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NYSDOH contributed $10,000 to help cover the costs incurred by the Migrant Health Center in support of the study and follow-up. The actual cost to the Health Center, however, was $15,000. The additional $5,000 had to be absorbed by the grantee.

SURVEY OUTCOMES

From the perspective of the Migrant Health Center, the CDC study had a number of positive outcomes: more than half of the 115 farmworkers screened were first-time users of the Migrant Health Center services; a number of serious STD cases, including HIV and syphilis cross-infection, were found and treated; data from the study will be used to document STD, HIV and TB morbidity for migrant farmworkers in the region; and promised collaboration both with the CDC and the NYS Department of Health will yield further cooperative efforts and hopefully, future funding opportunities. More specifically, the screening results indicated a 36% TB positivity, 6% HIV positivity, and 32% syphilis positivity. In addition, 32% of those tested were found to lack immunity to the Hepatitis B virus.

Many of the difficulties experienced in executing the screening had been anticipated by the Migrant Health staff. Indeed, these difficulties are among the perennial barriers to care with which farmworkers and Migrant Health programs throughout the country must contend. They include: limited hours of access both by farmworkers to health care, and by providers to farmworkers because of work schedules; language and cultural barriers; travel distances and lack of transportation for follow-up; limited access to treatment (especially chronic care); inefficient transfer of medical information upstream and downstream; underdeveloped linkages with county departments of health; and limited staff and financial resources of HVMH for the extensive follow-up required, especially at the height of the season when the study/screening was conducted. Unanticipated problems were encountered when physicians doing follow-up care refused to accept the screening's test results and the

recommendations of the New York State Department of Health regarding treatment. This led to duplication of effort, a substantial increase in costs and follow-up time, and the loss of some study participants who left the area as the season ended.

ACCESSIBILITY OF CARE

It is estimated that federally-supported primary care services for migrant and seasonal farmworkers (MSFWs) and their families meet less than 20% of the need in the nation. Hudson Valley Migrant Health, working in five counties with an estimated MSFW population of 6,800, saw 2,300 patients for at least one primary care visit during the 1992 season, a significantly high penetration rate of nearly 35%. While HVMH operates efficiently, the CDC screening demonstrated how fragile this system of care is, and how quickly it can be overwhelmed. With two full-time staff responsible for both administration and outreach, and only one dedicated migrant clinic site in the five-county service area, the program is dependent upon whatever aggregation of part-time, contracted and volunteer providers can be recruited in a given season. There is a dearth of private practice physicians in the Hudson Valley rural areas where migrant and seasonal farmworkers live and work, and few who will see them as patients. Fewer still accept medicaid reimbursement.

The problem of accessibility was exacerbated by the CDC screening activity. In Ulster County, where the Migrant Health Center operates at capacity during the season, the 67 screenings generated an additional 16 syphilis cases, 32 positive PPDs, 4 positive HIVs, and 32 patients requiring Hepatitis B vaccine. With the Migrant Health Program's limited resources already stretched thin by the normal flow of activities, the follow-up care for these patients, including x-rays and other diagnostic procedures, clinic visits, counseling visits, monitored medication and vaccination regimes, and the provision of transportation and interpretation for all these needs, became a logistical nightmare and a financial drain on the program.

LINKAGES WITH COUNTY DEPARTMENTS OF HEALTH

The large number of migrants screened and in need of follow-up in Ulster County, together with the small number of Migrant Health clinical and outreach staff and limited clinic hours, provides a clear example of a situation in which support from a county department of health can make a significant difference to the kind of public health undertaking being described here. Though the numbers of migrants screened in Orange County (37) and Putnam County (11) were smaller than in Ulster County, the follow-up would still have been an almost impossible burden without the active cooperation of county departments of health. Cooperation has generally been the rule, but the budget constraints of the past two years have taken its toll. Lacking such cooperation, whether due to budget constraints or for other reasons, the Migrant Health Program would be forced to refocus on providing comprehensive primary health care services and leave public health screenings to the agencies responsible for such activities.

TRANSPORTATION

Transportation is always a major issue in any effort to provide health care services to migrant and seasonal farmworkers. Very few migrants have cars, and their workplace and housing are usually located far from health facilities and doctors' offices. Of all the efforts by Migrant Health staff in support of the screening and follow-up, nothing was as problematic as the attempt to ensure that farmworkers who had appointments for further diagnostic work, medical visits, counseling, treatment, and even hospitalization, did not miss those appointments for lack of transportation. One measure of the dimensions of this effort is the 4,471 miles driven by Migrant Health staff during the six-week period of the screening and initial follow-up. This figure does not include the mileage of other vehicles, such as the Health Center's mobile medical van, nor does it represent the miles driven by CDC, NYSDOH, and County DOH personnel.

TRANSFER OF INFORMATION

Because of their mobility, often dubious legal status, and lack of access to continuous health care, migrant farmworkers and their medical records (when they exist) are especially difficult to track. In this study, tracking, reporting, and transferring information downstream to homebase states were to be the joint responsibility of NYS Department of Health STD and TB Control Programs, and Hudson Valley Migrant Health, with some participation from the county departments of health. For the most part, however, the bulk of the work fell to the Migrant Health Program as part of its follow-up efforts. As for the local departments of health, Putnam County was most active in attempting to follow-up on the screening, including referrals and transfer of medical information.

FOLLOW-UP CARE

One problem that was unanticipated was the refusal of two referring physicians to accept the positive test results identified during the screening or the recommendations for treatment issued by the New York State Department of Health. Several patients were retested and then treated, and another patient was retested with no treatment ordered. The radical difference between a recommendation for a 10-day hospitalization for IV penicillin on the one hand, and no drug therapy at all on the other, highlights the remarkable disparity in the local physicians' practice patterns and acceptance of public health treatment guidelines.

RECOMMENDATIONS

As indicated in the beginning of this report, most of the problems encountered in attempting to facilitate the CDC screenings were predictable -- the common currency of bringing health care services to migrant farmworkers. This, not to diminish the importance of these problems, but to point out the difficulties faced every day by farmworkers attempting to access health care for themselves and their families. The health programs such as Hudson Valley Migrant Health, with relatively few

resources, are equally overwhelmed in their attempt to meet at least some of the needs of the migrant population.

By all indications, additional state and federal resources are critical to ensure adequate follow-up and access to comprehensive health care. Moreover, to be effective, these resources must flow from the governmental agencies directly to the community-based primary care delivery system.

Based on these experiences, the following recommendations are offered:

1) PROMOTE A PARADIGM SHIFT away from the view of farmworkers as replaceable or even expendable laborers and towards an appreciation of their critical role in a significant sector of the state and national agricultural economy. To this end, there is a clear need for decent housing, working conditions that are fair, legal and safe, as well as access to quality health care and education.

2) CLOSER COLLABORATION AND BETTER COORDINATION: There is a need for closer collaboration and better coordination among and between the various agencies concerned with the health and well-being of migrant farmworkers, particularly at the state level. In order for collaboration to succeed, however, there must be a clearer understanding of each agency's role, philosophy, scope of services, resources, and capabilities.

This collaboration must take place at many different levels: CDC with the state department of health (SDOH) and the migrant/community health centers; local health departments with migrant/community health centers; SDOH and other state agencies, such as the department of social services, housing, mental health, rural health, substance abuse and alcohol services, department of labor, and state medicaid offices. Moreover, collaboration among agencies takes adequate lead time and requires good

communication and trust. More time for planning would have enhanced communication and coordination, and improved project outcomes.

3) EFFICIENT UTILIZATION OF FINITE RESOURCES: This could be achieved by designating a full-time Migrant Program Specialist within the State Department of Health to be responsible for all migrant funding, programming, and evaluation. The Migrant Program Specialist could coordinate all department migrant activities, and handle interdepartment and interagency coordination and communication. For example, this individual could work with the State to promote the outstationing of medicaid eligibility workers in Migrant Health clinics. This person could also lead the State's ongoing communications with other states and health providers regarding migrant follow-up, collaborating on such crucial issues as the development of uniform medical information collection, tracking, and transfer systems. Interstate follow-up for TB positive patients would be made possible having such a person responsible as well.

4) PARTICIPATE IN A MEDICAID INTERSTATE COMPACT STUDY: Of the 115 farmworkers screened in the CDC study, 35 were known to be from Florida. With information collected during the registration process (name, social security number, date of birth), the Migrant Health Center was able to track 25 of these workers to determine Florida medicaid status. Five were ultimately found to have medicaid, but in Florida, medicaid covers only "emergency" care out of state. Thus, the Migrant Health Center would not be reimbursed for services to these patients and must absorb the expense of having provided the care.

Since many migrant farmworker families experience similar difficulties receiving medicaid benefits as they travel from state to state, one possible remedy is to use an approach known as "Medicaid Interstate Compacts." Federal guidelines grant authority to state medicaid agencies to enter into an agreement under which the medicaid card issued by one state can be honored by another state. As recommended, a Migrant Program Specialist, working with the state and the relevant

downstream states — principally Florida and Texas in New York's case — would be well-situated to help realize such agreements as a precursor to a nationally-administered health plan for migrant and seasonal farmworkers. To this end, state medicaid directors should be encouraged to participate in the Health Care Financing Administration (HCFA) study of Medicaid Interstate Compacts.

5) ADOPT A FEDERALLY-ADMINISTERED SINGLE PAYER SYSTEM INSTEAD OF MANAGED COMPETITION: Migrant and seasonal farmworkers should be exempted from the state-based, regional HIPC or Health Alliances currently being proposed by the Clinton Administration. Instead, recognizing the unique circumstances and needs of farmworkers, a federally-financed single payer system should be used to assure accessible, continuous and comprehensive care, across state lines. Amending Title 18 (Medicare) to include enhanced services and assure a national funding stream would be one solution to assuring migrant health care from state to state.

6) ESTABLISH CORE BENEFITS FOR MIGRANTS: OUTREACH, EDUCATION, TRANSLATION, AND TRANSPORTATION SERVICES: Outreach and health education are vital building blocks of a comprehensive, community-oriented primary care system. These components serve as common elements shared by public health departments and comprehensive Migrant Health Centers. Migrant and seasonal farmworkers need to be reached in culturally-sensitive ways, and empowered through education to understand the conditions and risk behaviors that lead towards illness and disease. The Migrant Health Center, when properly funded, can provide the necessary outreach, education, screening, and follow-up as well as provide diagnosis, treatment, and culturally-sensitive services including translation and transportation. This assures a well-integrated system that meets the needs of the farmworker.

7) BUNDLE THE VARIOUS STATE CATEGORICAL PROGRAM FUNDS: The limited dollars available for categorical programs, such as STD, TB, HIV, Immunizations, Prenatal Outreach, WIC, and Substance Abuse and Alcohol, should be pooled to

support comprehensive approaches to providing a continuum of managed services to this population. Migrant Health Centers should be deemed eligible to receive grant dollars that traditionally have gone to the state or local health departments. Bundling categorical program funds and redistributing them can serve as an

incentive to grantees to structure programs in a more comprehensive and coordinated manner.

8) DEVELOP THE PUBLIC HEALTH INFRASTRUCTURE: The existing public health system must be supported as the essential communication link for the transfer of medical information and for follow-up throughout the country. In this regard it is especially important to secure funding for infrastructure development for the transfer of medical information from state to state and to assure computer capability adequate to the task.

9) INCREASE ROLE FOR THE PUBLIC HEALTH SERVICE: The federal Public Health Service (PHS) has a role in promoting cooperation between the CDC, state health departments and migrant/community health centers. PHS should require grantees to indicate collaboration in the federal grant application and in the state Memorandum of Agreement as recommended in the CDC's report, "Prevention and Control of Tuberculosis in Migrant Farm Workers," published in the June 5, 1992 issue of MMWR. PHS should also sign a Memorandum of Agreement with the CDC so that community-sponsored projects on a local level will be encouraged and enhanced.

CONCLUSION

Migrant and seasonal farmworkers are the backbone of America's agricultural work force. Their labor and skill make possible the abundance and low cost of the fruits and vegetables that fill our supermarket produce bins year round. Yet, in the words of a recent study of morbidity in the farmworker population, their "demographic patterns, socioeconomic conditions, life-style characteristics, and disease categories

reflect an agrarian society in a third-world country caught in an infectious disease cycle (Dever, 1991).

The results of this CDC study not only confirm these dismal conditions, but point out the failure of our health care delivery system to respond to the unique and complex nature of farmworker health issues.

It is now conceded that our health care system is inadequate to the needs of ever larger numbers of mainstream Americans, and that it is urgent that something be done. But if health care reform is urgent for those of us in the mainstream, what must it be for those on the margins, like farmworkers, who have always been relegated to the bottom rung of the health system ladder? The new American system must be built on sound organizational principals and good public health practices, including the integration and coordination of primary care with public health. Hopefully, these recommendations contribute to the discussion now under way on the state and national level and impact on the strategies being designed to improve access to comprehensive, continuous health care for migrant and seasonal farmworkers.